



FIREARMS HEALTH CERTIFICATION FORM

I, *[Doctor's Full Name]* _____, *[Doctor's Medical License Number]*
_____, a licensed and practicing physician in the field of *[Specialty]*
_____, hereby certify that after conducting a comprehensive medical evaluation of
[Full Name of Applicant] _____, *[Identification Card / Passport Number]*
_____, and also having reviewed their medical history, **I find no current medical or
psychological conditions that would impede their physical or mental fitness to keep and/or use a firearm.**

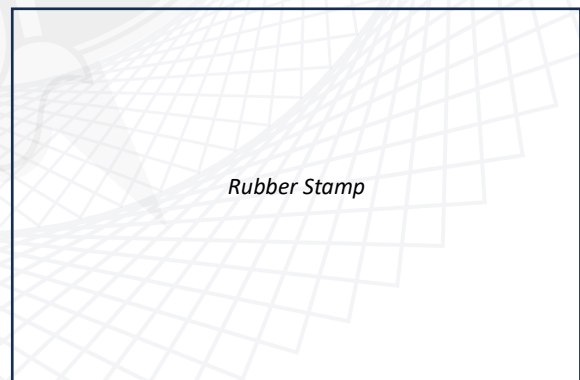
This certification is made in accordance with all applicable Maltese laws, regulations, and ethical standards governing medical practice. It is based on my professional judgment and expertise as a qualified medical practitioner. I affirm the accuracy and truthfulness of the information contained herein to the best of my knowledge and belief.

I also acknowledge that this certification will be used by the Malta Police Force as part of their assessment process for *[Full Name of Applicant]* _____ firearm license eligibility.

Signature: _____

Date: _____

*This certification reflects the applicant's health status
at the time of examination.*



DOCTOR'S FULL NAME, TITLE, AND CONTACT INFORMATION

[Name of Medical Practice, Clinic, or Hospital] _____

[Email Address] _____